



**Improving Health Outcomes**

Moving Patients Along the HIV Care Continuum

## **SPNS Workforce Capacity Building Initiative**

### **Correctional Health Services**

**Target Audience:** RWHAP and Other HIV Service Providers



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July 17, 2019



# Agenda

- **Overview**
  - About the Special Projects of National Significance (SPNS) Program & Integrating HIV Innovative Practices (IHIP) Project
- **Presenter**
  - **Alison O Jordan, LCSW**
    - *New York City Health & Hospitals  
Correctional Health Services  
New York, NY*
- **Q&A**



## Disclaimer

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## Presentation Outline

- Overview
- Correctional Health is Public Health
- Transitional Care Coordination
- Pay it Forward: Integration in Puerto Rico
- Implementation Challenges
- Lessons Learned & Recommendations



# Overview

## **Jail Linkages: 2007-2012**

NYC site found Latino/as less likely to remain engaged in care 6m after incarceration.

## **Latino Initiative: 2013-2018**

NYC CHS found most Latino/as in local jails are of PR origin; need culturally appropriate resources after incarceration.

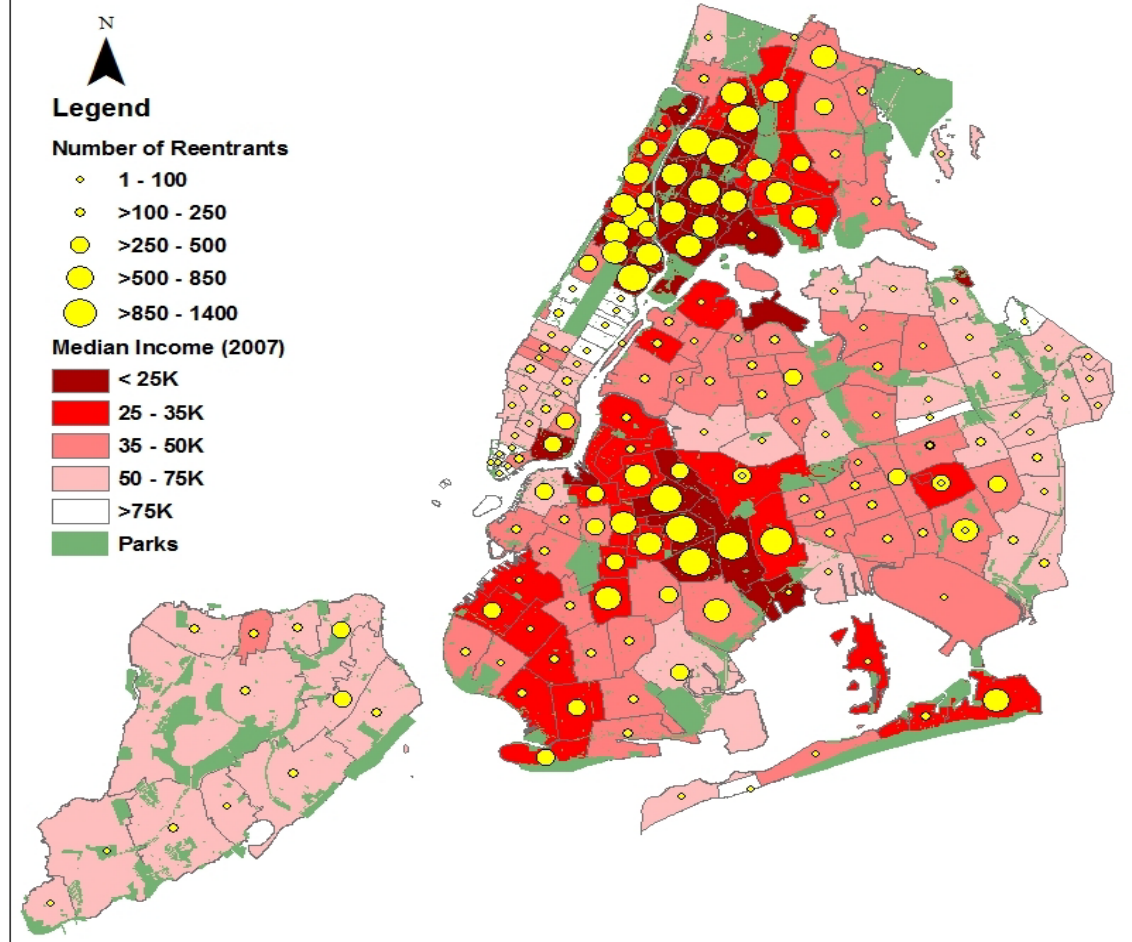
## **Workforce Capacity: 2014-2018**

NYC CHS Latino Initiative partner, One Stop Career Center of PR, to build collaboration & coordination with corrections and engage key stakeholders; NYC CHS/Reentry & Continuity Services develops workforce capacity in PR by training employment services staff in Transitional Care Coordination (TCC) intervention.



# Correctional Health is Public Health

Number of Discharges to the Community  
from NYC Jails by Zip Code  
and Socioeconomic Status for 2014



## Why Jails?

Over 70% of people released to the community after incarceration return to the areas of greatest socioeconomic and health disparities.

*Jordan AO, Cohen LR, Harriman G, Teixeira, PA, Cruzado-Quinones J, Venters H, Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island, AIDS Behav Oct 2013*



# Intersection of HIV/AIDS & Incarceration in Puerto Rico

- Puerto Rico (PR) has the 5<sup>th</sup> highest rate of new HIV diagnoses in the U.S.<sup>1</sup>
- PR has the 3<sup>rd</sup> highest rate of people living with HIV<sup>1</sup>
- PR has a high prison population rate (303 per 100,000):<sup>2</sup>
  - Over 11,000 incarcerated individuals
  - 98% are men in 7 correctional centers
  - 6.9% of people incarcerated in PR are living with HIV
- Puerto Ricans living with HIV and coming home after incarceration often need assistance, including housing, employment and transportation, to access available HIV care in Puerto Rico

1. CDC HIV Surveillance Report 2014, excludes DC (rates are per 100,000)

2. Rodriguez-Diaz CE, Rivera-Negron RM, Clatts MC, Myers JJ. 2014. Health Care Practices and Associated Service Needs in a Sample of HIV-Positive Incarcerated Men in Puerto Rico: Implications for Retention in Care. *J Int Assoc Provid AIDS Care*.



# Transitional Care Coordination

## **Jail-based Services**

- Opt-in Universal Rapid HIV Testing
- Primary HIV care and treatment including appropriate ARVs
- Treatment adherence counseling
- Health education and risk reduction

## **Transitional Care Coordination**

- Discharge Planning starting on Day 2 of incarceration
- Health Insurance Assistance / ADAP
- Health information/liaison to courts
- Discharge medications
- Patient Navigation including accompaniment, transport, and finding people lost to follow up
- Linkages to primary care, substance abuse and mental health treatment upon release

## **Community-based Services**

- Health Exam and Services
- Medical Case Management
- Linkages to Care
- Coordination of medical and social services
- Treatment adherence
- Assessment and placement for housing
- Health Insurance Assistance / ADAP





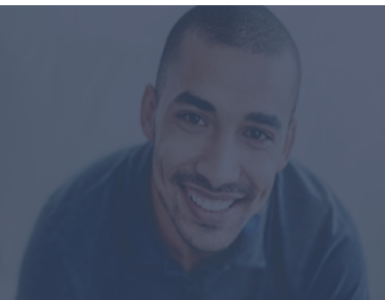
# NYC Provider Training

## Key Topic Areas

- Transnationalism
- Puerto Rican & Latino Culture
- Cultural Competency
- Strategies for Improving Care
- Also: Interactive activities

## NEW RESOURCES!

Culturally appropriate engagement  
with Latinos/as to enhance linkage  
and retention to HIV care



A webinar series about Culturally Appropriate Engagement and Service Delivery with Latino/as to Enhance Linkage and Retention to HIV Primary Care – including a Transnational Case Study for Puerto Ricans is now available for health and social service professionals! This Continuing Education activity is for physicians, nurses and Certified Health Educators, as well as other health and social service professionals. Accreditation for physicians, nurses, and Certified Health Educators as well as general CE is available (CME, CNE, CHEC and CEU).

This curriculum explains how to use four key frameworks which, when integrated, allow for the development of a provider-level strategy to improve the HIV primary care patient outcomes for Latinos/as who are incarcerated or have a history of incarceration. The case study provides a sub-analysis of transnationalism among Puerto Ricans.

These frameworks include:

1. **Cultural Formulation**, which analyzes cultural factors that affect clinical encounters, especially when the healthcare provider does not share the same cultural background as the patient.
2. **Transnationalism**, which represents the process by which immigrants forge and sustain multi-stranded social relations with their country/place of origin. It affects the social field of individuals, which includes their group identity, daily activities, neighborhoods/communities, economic opportunities, and social and political behaviors.
3. **DECIDE**, a six-step process for decision making.
4. **Shared Decision Making**, a strategy where patients and providers build a consensus on the treatment plan and agree on the steps necessary to implement it.

This webinar series is available for health and social service professionals! Continuing Education credits for physicians, nurses, Certified Health Educators as well as general CE credits (CME, CNE, CHEC and CEU) <http://www.bxconsortium.org/cewebinarseries.html>



# Linkage to Care Community Partner

## One Stop Career Center of Puerto Rico (OSCC)

- Partnership with PR Department of Correction Supports individuals coming home after incarceration
  - Job training and placement
  - Clear criminal records
  - Case management
  - Housing assistance
  - Eviction prevention
  - Life skills training

## Workforce Capacity Expansion

- HIV education in jails / prisons
- Transitional care coordination facilitates linkage to care
- Transportation to access care after incarceration





# Steps to Implementation

## Identify staff:

- Train staff in TCC
- State certified HIV counselors

## Transportation:

- Transportation Service
- Identify sustainable funding

## Coordinate with Corrections:

- Access to correctional facilities
- Patient health records

## Engage Key Stakeholders:

- Establish a Consortium
- Linkage Agreements
- Meet with Clients



# Workforce Capacity Building

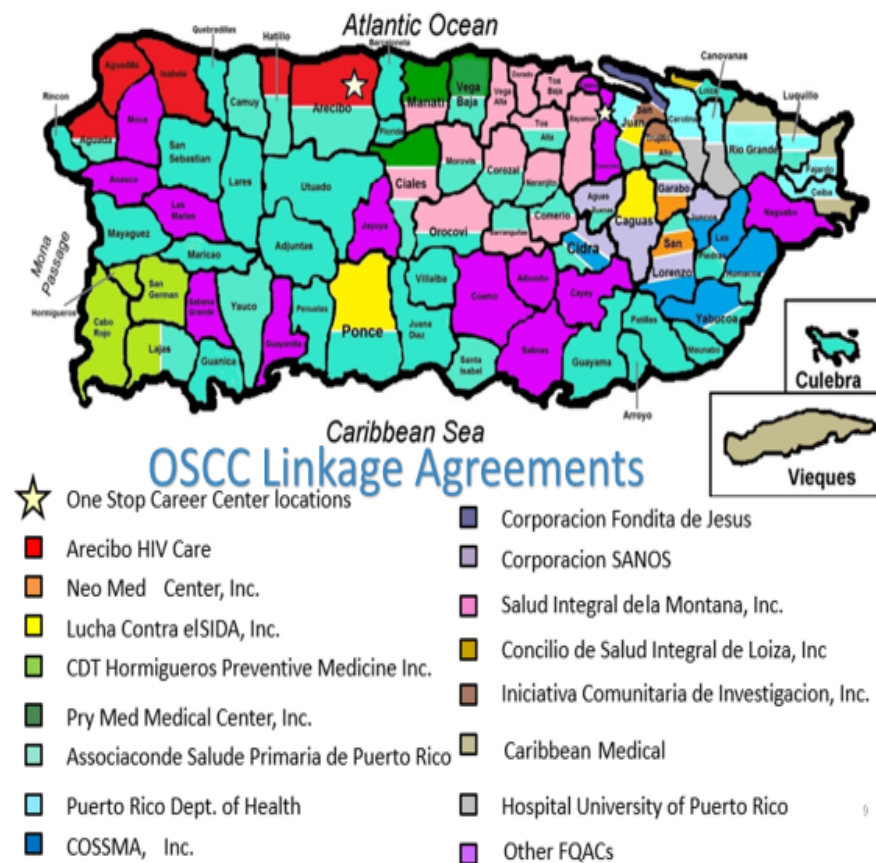
- Build on SPNS Latino Initiative to enhance collaboration and coordination among providers
- Train employment and housing specialists in Transitional Care Coordination
  - HIV education and risk reduction
  - Outreach & engagement
  - Transitional care planning
  - Coordination with service providers
  - Patient navigation after incarceration
- Conduct SPNS local evaluation
- Secure reliable transportation for clients



# Collaboration Outcomes

- Over 60 MOUs with service providers across PR to address housing, primary care, employment, and other social services
- Government and community partners launched Island-wide consortium to address needs of HIV+ clients transitioning to community after incarceration
  - Community providers – medical care, including HIV Primary Care, housing, substance use treatment, syringe exchange, support services, care management.
  - Federal agencies – Ryan White, US DO.
  - PR Department of Correction and Rehabilitation

## HIV Primary Care in PR





# Program Outcomes

- OSCC staff working in 13/32 correctional facilities in PR
- Prevention education/risk reduction sessions provided at jail orientations to identify potential clients (n=360)
- 69 enrolled and completed baseline
  - All received transitional care coordination
  - 10 additional served as part of pilot
- 58 returned to community after incarceration
  - 54 of 58 eligible (93%) linked to HIV primary care and other services after incarceration
  - All 10 (100%) pilot participants linked to care

## ***Housing & Employment***

Housing: 22

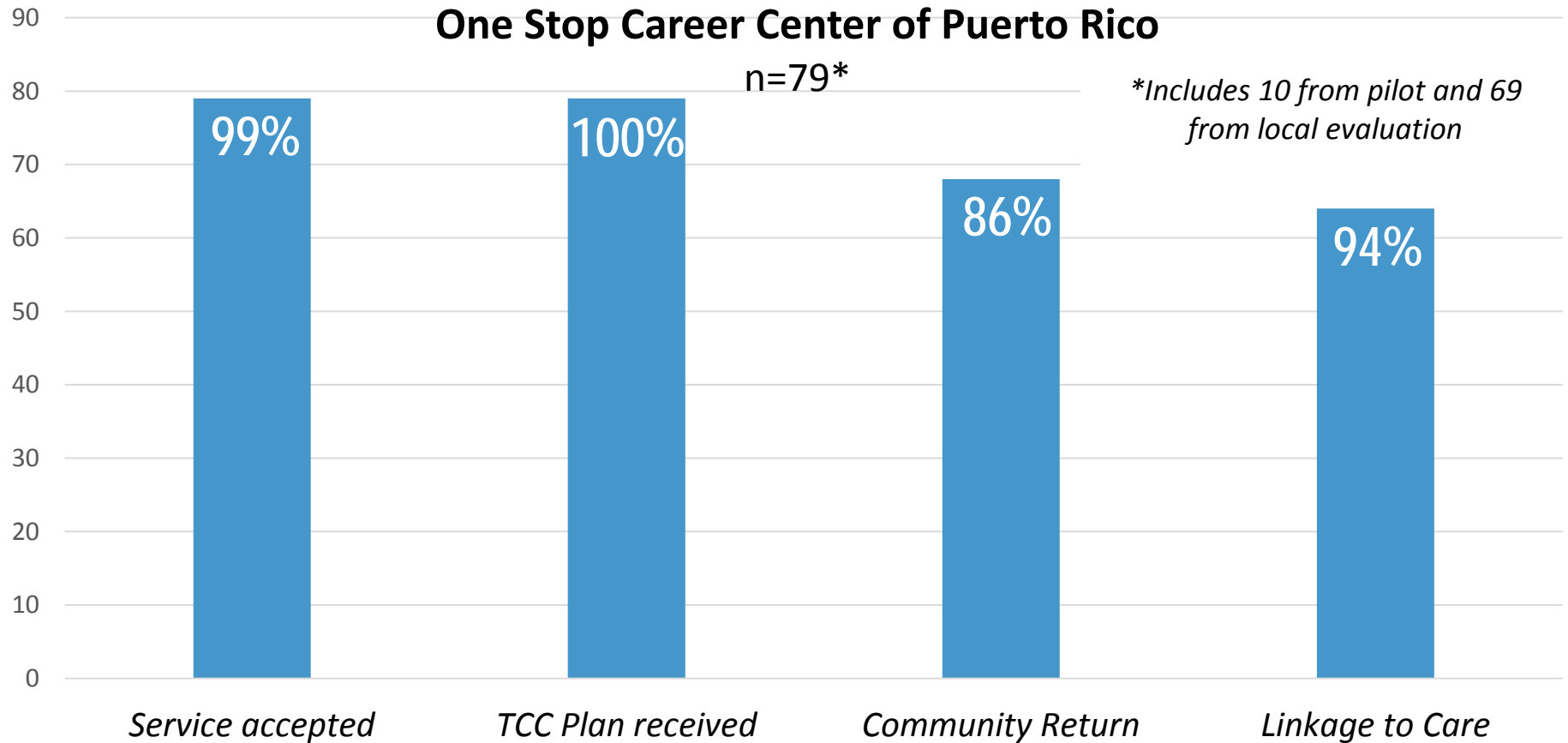
- 19 transitional
- 5 permanent

Job readiness: 15

- 12 employed;
- 1 volunteer;
- 2 seeking employment

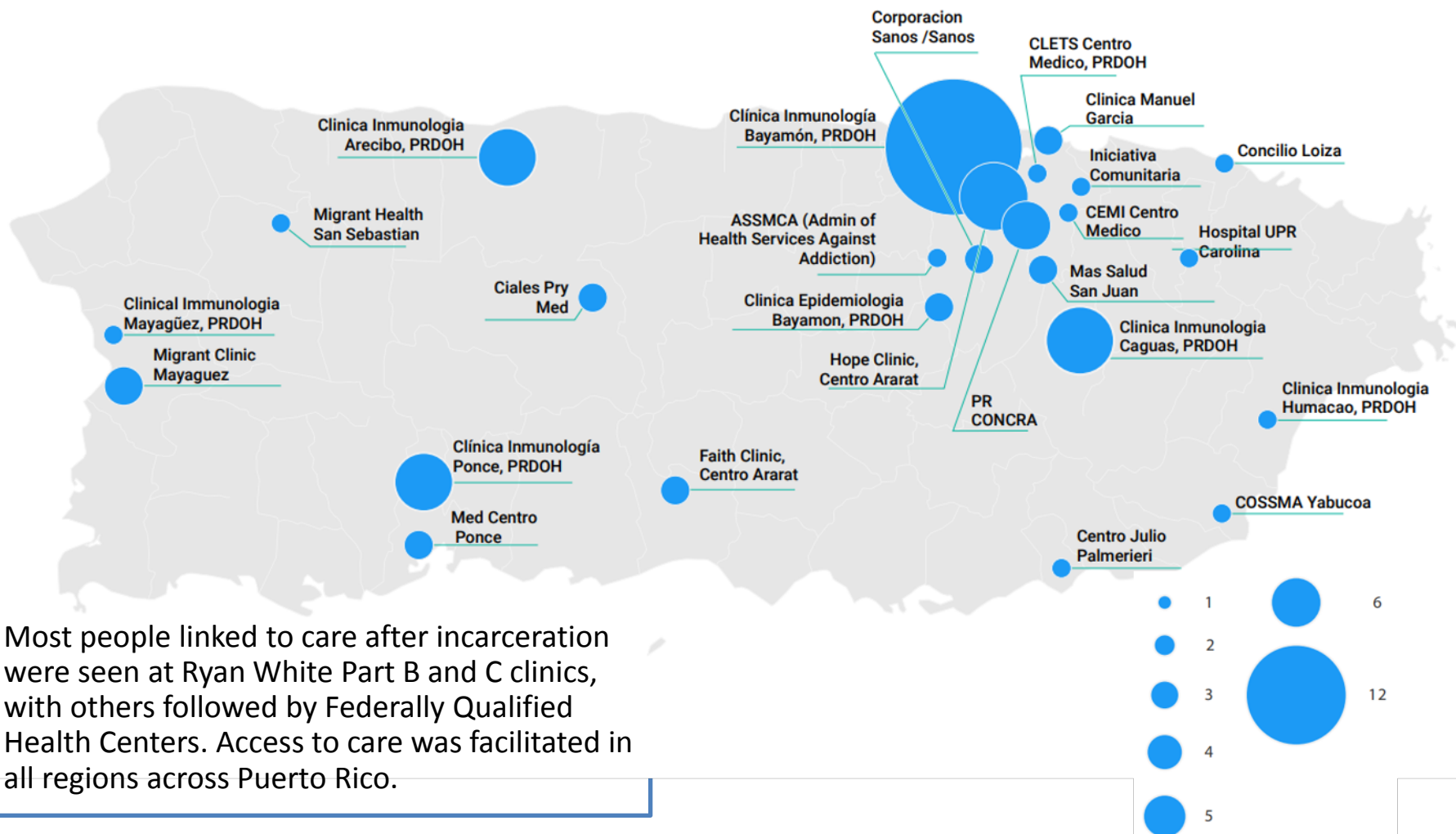


# Transitional Care Coordination Cascade





# Linkages to Care in Puerto Rico







# Sustainability

## Puerto Rico Empleo, Vivienda y Salud Resource Guide

Results 199

Map

Satellite

CONCRA (Community Network FOR Clinical Research on AIDS)

Calle Brumbaugh #1162, Urb. Garcia Ubarri, San Juan, PR 00925

Rosaura López Fontáñez, Directora Ejecutiva

rlopez@prconcra.net

787-773-0464

787-294-1569

Homepage

6 services offered at this location

Iniciativa Comunitaria de Investigación, Inc. Programa Pitirre

Calle Quisqueya, 61 Esquina, Hato Rey, PR 00918

José A. Vargas Vidot, Executive Director

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787 - 250 - 8629, Ext. 208

787 - 753 - 4454

Homepage

5 services offered at this location

Iniciativa Comunitaria de Investigación, Inc. Programa Pitirre

P.O. Box 366535, San Juan, PR 00936-6535

José A. Vargas Vidot, Executive Director

The Puerto Rico Employment, Housing and Health Resource Guide is available at no cost to network providers through RDE eCompas and includes icons that depict available services, such a hospital for medical care, a house for housing and a suitcase for employment services and a handshake for care coordination.

<https://nrg.e-compas.com/pr/>



# Implementation Challenges

- Identifying right fit programs: personal relationships v. formal expertise
- Proposal evaluation methodology favors existing programs
- Formal authority/documents from predecessors are insufficient to gain buy-in
- Culture of corrections varies by location/jurisdiction
- Opening/closing of programs absent formal communication system
- Frequent turnover and changes in local government leadership
- Poor local economy, lack of affordable housing/shelters
- Hurricane Maria...



# Hurricane Maria Relief Efforts

OSCC received hurricane relief funding and found clients after Hurricane Maria to assess need and arrange for:

- Medications
- Housing
- Food, drinking water, clothes and other needs
- Assistance with FEMA application
- Placement in transitional housing / treatment



# Overcoming Challenges

## Manati

**After Hurricane Maria**



Photo by: Brenda Rosario

**February 2019**



Photo by: Alison O Jordan



# Lessons Learned & Recommendations

1. Networking with other agencies & jurisdictions identified core organizations and champions
2. Local community/faith-based organization (CBO) leadership pooled resources and worked with government staff to establish best practices to facilitate continuity of care
3. Coordination & collaboration between Ryan White service network and local CBOs improved access for those out of care.
4. Pre-established relationships led to formal agreements & created synergy among medical and support service providers (housing, employment, substance use)
5. OSCC participation on HIV Planning Council facilitated coordination with key stakeholders
6. Annual convening of stakeholders helped create strategies to address population needs
7. Maintain relationships and linkage agreements
8. Transitional Consortium maintained core leadership, supported relationships & leveraged resources to coordinate care
9. Engaging client during incarceration fosters relationships to endure after incarceration
10. Transportation access ensures linkage to care after incarceration





**NYC**  
**HEALTH+**  
**HOSPITALS**

# Correctional Health Services





## Connect with SPNS

Sharing Information & Strategies

For questions, email

[SPNS@hrsa.gov](mailto:SPNS@hrsa.gov)

To join the IHIP Listserv, visit

<https://targethiv.org/ihip>



## Connect with HRSA

To learn more about our agency, visit  
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